

02080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard Co.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage		c. LENGTH OF STAY IN 1b 30 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						d. STREET ADDRESS Commercial St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Emory C. Condon						4. DATE OF DEATH Feb. 1 - 1960			19		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1884		9. AGE (In years ^{last birthday}) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator				10b. KIND OF BUSINESS OR INDUSTRY Cotton Mill		11. BIRTHPLACE (State or foreign country) Carroll Co. Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Edward F. Condon						14. MOTHER'S MAIDEN NAME Sarah J. West					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 213-01-7668		17. INFORMANT James H. Condon, Savage, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Asthmatic attacks 241X DUE TO Chr. Asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 yrs. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Myocardial Insuff.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) th		20f. (City or town) Feb. 1st		(County) (State)	
21. I certify that I attended the deceased from Jan. 27, 1960 to Feb. 1st, 1960 , that I last saw the deceased alive on Feb. 1st, 1960 , and that death occurred at 10:30 P. M., from the causes and on the date stated above.											
ACTUAL SIGNATURE Frank E. Shipley				DATE SIGNED Savage, Md.							
PHYSICIAN'S NAME (Type) Frank E. Shipley											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 4, 1960		22c. NAME OF CEMETERY OR CREMATORY Savage Cemetery			22d. LOCATION (City, town, or county) (State) Savage, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Canalehan, Laurel, Md.						24a. REC'D BY REGISTRAR DATE FEB 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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INVESTIGATIVE DEPARTMENT OF HEALTH - ACTION ONE 10

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2087 CERTIFICATE OF DEATH

02081

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 03 55.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer Nursing Home		d. STREET ADDRESS 8703 Loch Bend Drive	
3. NAME OF DECEASED (Type or print) First Jennie Middle H. Frederick Last		4. DATE OF DEATH Month February Day 20 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1872
9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR: Months 03 Days 55 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co. Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David H. Frederick		14. MOTHER'S MAIDEN NAME Elizabeth Ann Frizell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Bessie A. Frederick		Address Same	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 4 da
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-8 19 59 to 2-20 19 60 , that (I) (we) lost the deceased alive on 2-20 19 60 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Herbert		22b. DATE SIGNED 2-22-60	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas F. Herbert		22d. ADDRESS Church Road, Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-23-60	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City, town, or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		25a. REC'D BY REGISTRAR DATE FEB 23 '60	
		25b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

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UNITED STATES OF AMERICA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES
BUREAU OF VETERANS AFFAIRS
OFFICE OF THE ASSISTANT SECRETARY
FOR VETERANS AFFAIRS
WASHINGTON, D.C. 20460
VETERANS BENEFITS
10-100 (Rev. 1-78)

10-100

1. NAME (Last, First, Middle Initial)
2. SOCIAL SECURITY NUMBER
3. DATE OF BIRTH (Month/Day/Year)
4. PLACE OF BIRTH (City, State, Country)
5. CURRENT ADDRESS (Street, City, State, ZIP)
6. HOME PHONE NUMBER
7. MAILING ADDRESS (Street, City, State, ZIP)
8. DATE OF ENTRY INTO SERVICE (Month/Day/Year)
9. DATE OF SEPARATION (Month/Day/Year)
10. TYPE OF SERVICE (Active, Reserve, National Guard, etc.)
11. BRANCH OF SERVICE (Army, Navy, Air Force, etc.)
12. GRADE OR RATE
13. DUTY STATION
14. DATE OF LAST PAYMENT (Month/Day/Year)
15. PAY GRADE
16. PAY RATE
17. DATE OF LAST PAYMENT (Month/Day/Year)
18. PAY GRADE
19. PAY RATE
20. DATE OF LAST PAYMENT (Month/Day/Year)
21. PAY GRADE
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23. DATE OF LAST PAYMENT (Month/Day/Year)
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26. DATE OF LAST PAYMENT (Month/Day/Year)
27. PAY GRADE
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41. DATE OF LAST PAYMENT (Month/Day/Year)
42. PAY GRADE
43. PAY RATE
44. DATE OF LAST PAYMENT (Month/Day/Year)
45. PAY GRADE
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47. DATE OF LAST PAYMENT (Month/Day/Year)
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51. PAY GRADE
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93. PAY GRADE
94. PAY RATE
95. DATE OF LAST PAYMENT (Month/Day/Year)
96. PAY GRADE
97. PAY RATE
98. DATE OF LAST PAYMENT (Month/Day/Year)
99. PAY GRADE
100. PAY RATE

2094

CERTIFICATE OF DEATH

Reg. Dist. No.

02082

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup				c. LENGTH OF STAY IN 1b Jessup			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ROSELIN Middle HARDING Last HARDING				4. DATE OF DEATH Month Feb. Day 6, Year 19 60			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1959	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months 26 Days 26 Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland (Baltimore)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Harding				14. MOTHER'S MAIDEN NAME Hilda Carroll Coleman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Thomas Harding Address Jessup, Md. Box 179			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Virus Infection 096.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While o. m. p. m. 19 Not while o. m. p. m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/26, 1959 to 2/6, 1960 that I last saw the deceased alive on 2/6, 1960 , and that death occurred at Jessup, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2/6/60							
ACTUAL SIGNATURE J M Warren M.D.				PHYSICIAN'S NAME (Type) Robert L. Howard			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/9/60		22c. NAME OF CEMETERY OR CREMATORY Guilford Baptist.,	
22d. LOCATION (City, town, or county) (State) Jessup, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Howard ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE FEB 10 '60		24b. REGISTRAR'S SIGNATURE C. E. K.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2093

CERTIFICATE OF DEATH

02083

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sanage</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sanage</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Guilford Road</u>				d. STREET ADDRESS <u>1 Guilford Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES L. HEISHMAN</u>				4. DATE OF DEATH <u>February 12 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1908</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Yard</u>		11. BIRTHPLACE (State or foreign country) <u>Edinburgh, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James M. Heishman</u>				14. MOTHER'S MAIDEN NAME <u>Ada Laura Litten</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-26-2007</u>		17. INFORMANT <u>Mrs. Elma Heishman, Sanage Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis Liver</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Alcoholic Mellitus</u> (c) <u>Carcinoma site unknown</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>8/23, 1944</u> , to <u>2/12, 1960</u> , that I last saw the deceased alive on <u>2/2, 1960</u> , and that death occurred at <u>6:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>J. M. Warren</u>				DATE SIGNED <u>2/12/60</u>			
PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
<u>Burial</u>	<u>2/15/60</u>	<u>Sanage Cemetery</u>		<u>Sanage Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willie Donaldson, Laurel, Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 19 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2088

CERTIFICATE OF DEATH

02084

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Indiana b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 12 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Michigan City 52 X-3		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sadie Hirsch		4. DATE OF DEATH Month Day Year February 29 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov 7, 1899
9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Ignatz Kline	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address hospital record Taylor Manor Hosp Ellicott City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Schizophrenia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr 27 , 19 57 , to Feb 29 , 19 60 , that I last saw the deceased alive on Feb 29 , 19 60 , and that death occurred at 8 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Taylor Manor Hospital 2/29/60			
ACTUAL SIGNATURE Irving J. Taylor		M.D. Taylor Manor Hospital	
PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D.		Taylor Manor Hospital, Ellicott City, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 3/3/60	22c. NAME OF CEMETERY OR CREMATORY Greenwood	22d. LOCATION (City, town, or county) (State) Michigan City, Ind
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham		ADDRESS Ellicott City, Md.	
24a. REC'D BY REGISTRAR DATE MAR 3 '60		24b. REGISTRAR'S SIGNATURE William S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1980-1981, 1982-1983, 1984-1985, 1986-1987, 1988-1989, 1990-1991, 1992-1993, 1994-1995, 1996-1997, 1998-1999, 2000-2001, 2002-2003, 2004-2005, 2006-2007, 2008-2009, 2010-2011, 2012-2013, 2014-2015, 2016-2017, 2018-2019, 2020-2021, 2022-2023, 2024-2025, 2026-2027, 2028-2029, 2030-2031, 2032-2033, 2034-2035, 2036-2037, 2038-2039, 2040-2041, 2042-2043, 2044-2045, 2046-2047, 2048-2049, 2050-2051, 2052-2053, 2054-2055, 2056-2057, 2058-2059, 2060-2061, 2062-2063, 2064-2065, 2066-2067, 2068-2069, 2070-2071, 2072-2073, 2074-2075, 2076-2077, 2078-2079, 2080-2081, 2082-2083, 2084-2085, 2086-2087, 2088-2089, 2090-2091, 2092-2093, 2094-2095, 2096-2097, 2098-2099, 2100-2101, 2102-2103, 2104-2105, 2106-2107, 2108-2109, 2110-2111, 2112-2113, 2114-2115, 2116-2117, 2118-2119, 2120-2121, 2122-2123, 2124-2125, 2126-2127, 2128-2129, 2130-2131, 2132-2133, 2134-2135, 2136-2137, 2138-2139, 2140-2141, 2142-2143, 2144-2145, 2146-2147, 2148-2149, 2150-2151, 2152-2153, 2154-2155, 2156-2157, 2158-2159, 2160-2161, 2162-2163, 2164-2165, 2166-2167, 2168-2169, 2170-2171, 2172-2173, 2174-2175, 2176-2177, 2178-2179, 2180-2181, 2182-2183, 2184-2185, 2186-2187, 2188-2189, 2190-2191, 2192-2193, 2194-2195, 2196-2197, 2198-2199, 2200-2201, 2202-2203, 2204-2205, 2206-2207, 2208-2209, 2210-2211, 2212-2213, 2214-2215, 2216-2217, 2218-2219, 2220-2221, 2222-2223, 2224-2225, 2226-2227, 2228-2229, 2230-2231, 2232-2233, 2234-2235, 2236-2237, 2238-2239, 2240-2241, 2242-2243, 2244-2245, 2246-2247, 2248-2249, 2250-2251, 2252-2253, 2254-2255, 2256-2257, 2258-2259, 2260-2261, 2262-2263, 2264-2265, 2266-2267, 2268-2269, 2270-2271, 2272-2273, 2274-2275, 2276-2277, 2278-2279, 2280-2281, 2282-2283, 2284-2285, 2286-2287, 2288-2289, 2290-2291, 2292-2293, 2294-2295, 2296-2297, 2298-2299, 2300-2301, 2302-2303, 2304-2305, 2306-2307, 2308-2309, 2310-2311, 2312-2313, 2314-2315, 2316-2317, 2318-2319, 2320-2321, 2322-2323, 2324-2325, 2326-2327, 2328-2329, 2330-2331, 2332-2333, 2334-2335, 2336-2337, 2338-2339, 2340-2341, 2342-2343, 2344-2345, 2346-2347, 2348-2349, 2350-2351, 2352-2353, 2354-2355, 2356-2357, 2358-2359, 2360-2361, 2362-2363, 2364-2365, 2366-2367, 2368-2369, 2370-2371, 2372-2373, 2374-2375, 2376-2377, 2378-2379, 2380-2381, 2382-2383, 2384-2385, 2386-2387, 2388-2389, 2390-2391, 2392-2393, 2394-2395, 2396-2397, 2398-2399, 2400-2401, 2402-2403, 2404-2405, 2406-2407, 2408-2409, 2410-2411, 2412-2413, 2414-2415, 2416-2417, 2418-2419, 2420-2421, 2422-2423, 2424-2425, 2426-2427, 2428-2429, 2430-2431, 2432-2433, 2434-2435, 2436-2437, 2438-2439, 2440-2441, 2442-2443, 2444-2445, 2446-2447, 2448-2449, 2450-2451, 2452-2453, 2454-2455, 2456-2457, 2458-2459, 2460-2461, 2462-2463, 2464-2465, 2466-2467, 2468-2469, 2470-2471, 2472-2473, 2474-2475, 2476-2477, 2478-2479, 2480-2481, 2482-2483, 2484-2485, 2486-2487, 2488-2489, 2490-2491, 2492-2493, 2494-2495, 2496-2497, 2498-2499, 2500-2501, 2502-2503, 2504-2505, 2506-2507, 2508-2509, 2510-2511, 2512-2513, 2514-2515, 2516-2517, 2518-2519, 2520-2521, 2522-2523, 2524-2525, 2526-2527, 2528-2529, 2530-2531, 2532-2533, 2534-2535, 2536-2537, 2538-2539, 2540-2541, 2542-2543, 2544-2545, 2546-2547, 2548-2549, 2550-2551, 2552-2553, 2554-2555, 2556-2557, 2558-2559, 2560-2561, 2562-2563, 2564-2565, 2566-2567, 2568-2569, 2570-2571, 2572-2573, 2574-2575, 2576-2577, 2578-2579, 2580-2581, 2582-2583, 2584-2585, 2586-2587, 2588-2589, 2590-2591, 2592-2593, 2594-2595, 2596-2597, 2598-2599, 2600-2601, 2602-2603, 2604-2605, 2606-2607, 2608-2609, 2610-2611, 2612-2613, 2614-2615, 2616-2617, 2618-2619, 2620-2621, 2622-2623, 2624-2625, 2626-2627, 2628-2629, 2630-2631, 2632-2633, 2634-2635, 2636-2637, 2638-2639, 2640-2641, 2642-2643, 2644-2645, 2646-2647, 2648-2649, 2650-2651, 2652-2653, 2654-2655, 2656-2657, 2658-2659, 2660-2661, 2662-2663, 2664-2665, 2666-2667, 2668-2669, 2670-2671, 2672-2673, 2674-2675, 2676-2677, 2678-2679, 2680-2681, 2682-2683, 2684-2685, 2686-2687, 2688-2689, 2690-2691, 2692-2693, 2694-2695, 2696-2697, 2698-2699, 2700-2701, 2702-2703, 2704-2705, 2706-2707, 2708-2709, 2710-2711, 2712-2713, 2714-2715, 2716-2717, 2718-2719, 2720-2721, 2722-2723, 27

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2095 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02085

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock		c. LENGTH OF STAY IN 1b Catonsville, 28	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cavey Lane		d. STREET ADDRESS 2202 Rock Haven Ave.	
3. NAME OF DECEASED (Type or print) Charles Henry Hoke		4. DATE OF DEATH Month Feb. Day 7 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/1893
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit	
11. BIRTHPLACE (State or foreign country) Klingerstown, Pa		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Hoke		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-9440	
17. INFORMANT Mrs. Clara M. Hoke, Catonsville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Vascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH - 10 mon. 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George E. Burgtorf		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) George E. Burgtorf M D		DATE SIGNED 2-8-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-60	
22c. NAME OF CEMETERY OR CREMATORY Iakeview		22d. LOCATION (City, town, or county) (State) Rt. 26 Baltimore County, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham		24a. REC'D BY REGISTRAR Ellicott City Md	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines		DATE FEB 9 '60	

1

2096

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02086

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Marriottville</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JAMES EMORY JOHNSON</i>		4. DATE OF DEATH <i>Feb. 14 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 10, 1879</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>labour</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	9. AGE (In years lost birthday) <i>80 yrs.</i>
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Ruby Davis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>—</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac failure, Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <i>edema - arteriosclerosis generalized</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1559 to 14 Feb 60</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1959</i> 19 <i>—</i> to <i>14 Feb 1960</i> , that (I) (we) last saw the deceased alive on <i>14 Feb 1960</i> , and that death occurred at <i>5 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard E. Hall</i>		22b. DATE SIGNED <i>2/15/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		22d. ADDRESS <i>Applaville, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2-17-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>West Liberty</i>	23d. LOCATION (City, town, or county) (State) <i>Applaville, Howard Co. Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>		25a. REC'D BY REGISTRAR <i>—</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>	
ADDRESS <i>Applaville, Md</i>		DATE <i>FEB 19 '60</i>	

2000

2000

2000

2000

2000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2097

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02087

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Berger Road				d. STREET ADDRESS Berger Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLEN CATHERINE KAHLER				4. DATE OF DEATH Month Feb. Day 10 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-3-1899	
9. AGE (In years last birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ednor, Md	
13. FATHER'S NAME John Coar				14. MOTHER'S MAIDEN NAME Mary Harding			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Adam Kahler, Jessups, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Strangulation by hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH instant			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Strangulation by hanging (self inflicted)					
20c. TIME OF INJURY Month, Day, Year Hour 5 P.M. a.m. 2-10-60 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At Home		20f. (City or town) (County) (State) Jessups Howard Co Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George E. Burgtorf M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George E. Burgtorf M D				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-60		22c. NAME OF CEMETERY OR CREMATORY St Pauls		22d. LOCATION (City, town, or county) (State) Fulton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE FEB 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

DATE SIGNED

2-12-60

MARYLAND STATE DEPARTMENT OF HEALTH - EASTHORE 18
1987 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, First, Middle Initial) JOHN EDWARD SMITH		2. SEX Male	
3. DATE OF BIRTH 11-15-1925		4. PLACE OF BIRTH St. Louis, Mo.	
5. SOCIAL SECURITY NUMBER 1-12-345678		6. MARITAL STATUS Married	
7. OCCUPATION Retired		8. PRESENT ADDRESS 123 Main St., Baltimore, Md. 21201	
9. DECEASED'S SIGNATURE John E. Smith		10. MEDICAL EXAMINER'S SIGNATURE Dr. J. K. Jones	
11. DATE OF DEATH 11-15-1987		12. TIME OF DEATH 10:15 AM	
13. PLACE OF DEATH Home		14. CAUSE OF DEATH (List in order) Myocardial Infarction	
15. MANNER OF DEATH Natural		16. ICD-9 CODE 410.91	
17. SIGNATURE OF MEDICAL EXAMINER Dr. J. K. Jones		18. SIGNATURE OF DECEASED John E. Smith	
19. SIGNATURE OF WITNESS John E. Smith		20. SIGNATURE OF WITNESS John E. Smith	

2089

CERTIFICATE OF DEATH

02088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN lb 9 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				3. NAME OF DECEASED First William Middle L Last Mazaroff			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				d. STREET ADDRESS 2812 N. Loudon Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month Feb. Day 16 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 13, 1890	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant-retired	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Abraham	
14. MOTHER'S MAIDEN NAME Tota		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Bert Mazaroff Address Don	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema bilateral DUE TO 480x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Myocardial failure, rt. sided DUE TO 72 hrs. (c) Influenza with broncho-pneumonia DUE TO 4 days				INTERVAL BETWEEN ONSET AND DEATH 36 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 10 , 19 60 , to Feb 16 , 19 60 , that I last saw the deceased alive on Feb 16 , 19 60 , and that death occurred at 5 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Taylor Manor Hospital DATE SIGNED 2/16/60							
ACTUAL SIGNATURE Stephen Lee Magness M.D.				PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremated				22b. DATE THEREOF 2-17-60			
22c. NAME OF CEMETERY OR CREMATORY United Hebrew				22d. LOCATION (City, town, or county) (State) Baltimore Md			
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewin ADDRESS 2100 Canton Place				24a. REC'D BY REGISTRAR FEB 18 60			
24b. REGISTRAR'S SIGNATURE Arthur S. Frank							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland.

2. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland.

3. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland.

4. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland.

5. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland.

6. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland.

7. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland.

8. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland.

9. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland.

10. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland.

CERTIFICATE OF DEATH

5082

1892

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. DATE OF DEATH</p> <p>10. TIME OF DEATH</p> <p>11. SIGNATURE OF PHYSICIAN</p> <p>12. SIGNATURE OF REGISTRAR</p> <p>13. SIGNATURE OF WITNESSES</p> <p>14. SIGNATURE OF DECEASED</p> <p>15. SIGNATURE OF NEXT OF KIN</p> <p>16. SIGNATURE OF CLERGYMAN</p> <p>17. SIGNATURE OF JUDGE</p> <p>18. SIGNATURE OF SHERIFF</p> <p>19. SIGNATURE OF CORONER</p> <p>20. SIGNATURE OF JURY</p> <p>21. SIGNATURE OF COURT</p> <p>22. SIGNATURE OF STATE</p> <p>23. SIGNATURE OF NATION</p> <p>24. SIGNATURE OF WORLD</p> <p>25. SIGNATURE OF UNIVERSE</p> <p>26. SIGNATURE OF GOD</p> <p>27. SIGNATURE OF DEVIL</p> <p>28. SIGNATURE OF ANGELS</p> <p>29. SIGNATURE OF DEMONS</p> <p>30. SIGNATURE OF SPIRITS</p> <p>31. SIGNATURE OF GHOSTS</p> <p>32. SIGNATURE OF PHANTOMS</p> <p>33. SIGNATURE OF SHADOWS</p> <p>34. SIGNATURE OF MISTS</p> <p>35. SIGNATURE OF FOGS</p> <p>36. SIGNATURE OF CLOUDS</p> <p>37. SIGNATURE OF STARS</p> <p>38. SIGNATURE OF PLANETS</p> <p>39. SIGNATURE OF MOONS</p> <p>40. SIGNATURE OF SUNS</p> <p>41. SIGNATURE OF FIRES</p> <p>42. SIGNATURE OF WATERS</p> <p>43. SIGNATURE OF EARTHS</p> <p>44. SIGNATURE OF AIRS</p> <p>45. SIGNATURE OF HEAVENS</p> <p>46. SIGNATURE OF HELL</p> <p>47. SIGNATURE OF PARADISE</p> <p>48. SIGNATURE OF ELYSIUM</p> <p>49. SIGNATURE OF BLISS</p> <p>50. SIGNATURE OF JOY</p> <p>51. SIGNATURE OF PEACE</p> <p>52. SIGNATURE OF LOVE</p> <p>53. SIGNATURE OF KINDNESS</p> <p>54. SIGNATURE OF MERCY</p> <p>55. SIGNATURE OF GRACE</p> <p>56. SIGNATURE OF FAITH</p> <p>57. SIGNATURE OF HOPE</p> <p>58. SIGNATURE OF CHARITY</p> <p>59. SIGNATURE OF WISDOM</p> <p>60. SIGNATURE OF UNDERSTANDING</p> <p>61. SIGNATURE OF KNOWLEDGE</p> <p>62. SIGNATURE OF TRUTH</p> <p>63. SIGNATURE OF JUSTICE</p> <p>64. SIGNATURE OF RIGHTEOUSNESS</p> <p>65. SIGNATURE OF VIRTUE</p> <p>66. SIGNATURE OF GOODNESS</p> <p>67. SIGNATURE OF BEAUTY</p> <p>68. SIGNATURE OF GLORY</p> <p>69. SIGNATURE OF HONOR</p> <p>70. SIGNATURE OF RESPECT</p> <p>71. SIGNATURE OF ADMIRATION</p> <p>72. SIGNATURE OF PRAISE</p> <p>73. SIGNATURE OF GLORIFICATION</p> <p>74. SIGNATURE OF EXALTING</p> <p>75. SIGNATURE OF ELEVATING</p> <p>76. SIGNATURE OF ENHANCING</p> <p>77. SIGNATURE OF EXALTING</p> <p>78. SIGNATURE OF ELEVATING</p> <p>79. SIGNATURE OF ENHANCING</p> <p>80. SIGNATURE OF EXALTING</p> <p>81. SIGNATURE OF ELEVATING</p> <p>82. SIGNATURE OF ENHANCING</p> <p>83. SIGNATURE OF EXALTING</p> <p>84. SIGNATURE OF ELEVATING</p> <p>85. SIGNATURE OF ENHANCING</p> <p>86. SIGNATURE OF EXALTING</p> <p>87. SIGNATURE OF ELEVATING</p> <p>88. SIGNATURE OF ENHANCING</p> <p>89. SIGNATURE OF EXALTING</p> <p>90. SIGNATURE OF ELEVATING</p> <p>91. SIGNATURE OF ENHANCING</p> <p>92. SIGNATURE OF EXALTING</p> <p>93. SIGNATURE OF ELEVATING</p> <p>94. SIGNATURE OF ENHANCING</p> <p>95. SIGNATURE OF EXALTING</p> <p>96. SIGNATURE OF ELEVATING</p> <p>97. SIGNATURE OF ENHANCING</p> <p>98. SIGNATURE OF EXALTING</p> <p>99. SIGNATURE OF ELEVATING</p> <p>100. SIGNATURE OF ENHANCING</p>	
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2090

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22 0353.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				d. STREET ADDRESS 3023 Dunglew Road			
3. NAME OF DECEASED (Type or print) First George Middle R. Last Norris				4. DATE OF DEATH Month Feb. Day 15 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 27, 1891		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Dealer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore County		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jacob Norris				14. MOTHER'S MAIDEN NAME Elizabeth ??(Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-28-6986		17. INFORMANT HOSPITAL RECORD Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Arteriosclerosis, generalized							INTERVAL BETWEEN ONSET AND DEATH 1 hr. unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome, associated with cerebral psychosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 13 , 19 58 , to Feb 15 , 19 60 , that I last saw the deceased alive on Feb 15 , 19 60 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Taylor Manor Hospital 2/15/60							
ACTUAL SIGNATURE Stephen Lee Magness M.D.				PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D. Taylor Manor Hospital, Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.				ADDRESS Dundalk 22, Md.		24a. REC'D BY REGISTRAR DATE FEB 17 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove rubber papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2098 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02090

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cooksville</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>WINFIELD S. PARKER</i>		4. DATE OF DEATH <i>Feb. 14 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 4, 1887</i>
9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Dennis Parker</i>		14. MOTHER'S MAIDEN NAME <i>Mollie Gosaway</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mrs Virginia Parker - Cooksville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial pneumonia, Cardiac failure, coronary thrombosis, arteriosclerosis generalized.</i> DUE TO (b) <i>491X</i> DUE TO (c) <i>14 Feb 60</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Jan 60</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1960</i> to <i>14 Feb 1960</i> that (I) (we) last saw the deceased alive on <i>14 Feb 1960</i> and that death occurred at <i>6:15 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard E. Hall</i>		22b. DATE SIGNED <i>2/15/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		22d. ADDRESS <i>Spesville, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-18-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Bushy Park</i>		23d. LOCATION (City, town, or county) (State) <i>Cooksville, Howard Co., Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur E. Hight</i>		25a. REC'D BY REGISTRAR <i>FEB 19 60</i>	
ADDRESS <i>Spesville, Md</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Hight</i>	

100-30

CERTIFICATE OF DEATH

2002

1

2093

CERTIFICATE OF DEATH

02091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Elkridge 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5609 Main St.		d. STREET ADDRESS Meadowridge Ave. Box 314		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SUSANNA PETERSON		First Middle Last		4. DATE OF DEATH Month Day Year 2-22-1960 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-28-1891	9. AGE (In years last birthday) yrs. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Louise Tiechman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-34-1615		INFORMANT Address Howard Peterson, Elkridge, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion 2 hrs 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Cardio Vascular Disease 5 1/2 hrs DUE TO (c) Arterial Hypertension 5 1/2 hrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Obesity					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan 20, 1960 to Feb 22, 1960 , that I last saw the deceased alive on Feb-22, 1960 , and that death occurred at 10:25 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE B B Brumbaugh M.D.		ADDRESS (Street, city or town, state) 5609 Main St Elkridge 27 Md		DATE SIGNED 2/22/60	
PHYSICIAN'S NAME (Type) B B Brumbaugh					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-60		22c. NAME OF CEMETERY OR CREMATORY Meadowridge	
22d. LOCATION (City, town, or county) (State) Elkridge, Md					
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 25 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REPORT OF THE
COMMISSIONER OF HEALTH
ON THE
MORBIDITY AND MORTALITY
IN THE
CITY OF NEW YORK
FOR THE
YEAR 1901



NEW YORK: PUBLISHED BY THE
DEPARTMENT OF HEALTH,
1902.

1 ~~X~~
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2100 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02092

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City - RURAL</u>			c. LENGTH OF STAY IN 1b <u>RFD#1, Ellicott City</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shaffers' Convalescent Retreat</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>CLARA L. Seicke</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-88</u>		9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Jacob Ammenhenuser</u>			14. MOTHER'S MAIDEN NAME <u>Louise</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Edward Kreis, Ellicott City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>stoking the underlying cause lost.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pathologic fracture, left femur, 4 wks. prior to death</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 dca.</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Thomas F. Herbert</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
22d. LOCATION (City, town, or county) <u>Baets</u>		(State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>MacNolt & Son Catonsville</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2091

CERTIFICATE OF DEATH

Reg. Dist. No.

02093

1. PLACE OF DEATH a. COUNTY Howard County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Home				d. STREET ADDRESS 2915 Oak Hill Ave.			
3. NAME OF DECEASED (Type or print) First Louise Middle — Last WARNER				4. DATE OF DEATH Month FEB. Day 27 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1879		9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank E. Schneider				14. MOTHER'S MAIDEN NAME Katherine Zeller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. —		INFORMANT John L. Warner 2434 Brambleton Road.		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-27 , 19 53 , to 2-27 , 19 60 , that I last saw the deceased alive on 2-27 , 19 60 , and that death occurred at 3:20 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Herbert		M.D. —		ADDRESS (Street, city or town, state) 46 Church Road		DATE SIGNED 2-27-60	
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		Ellicott City, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/60		22c. NAME OF CEMETERY OR CREMATORY Druid Edge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.				24a. REC'D BY REGISTRAR MAR 2 '60		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

08042

REF ID: A66138

CERTIFICATE OF DEATH

1903

DEPARTMENT OF HEALTH - NEW YORK